

Kentucky Medicaid Expansion Waiver

Kentucky expanded Medicaid to adults with income below 138 percent of the federal poverty level (FPL) in 2014 under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). On January 12, 2018, Kentucky received federal approval to transition its expansion population, as well as some pre-expansion populations, into a five-year Section 1115 demonstration waiver effective through September 30, 2023. The waiver, Kentucky Helping to Engage and Achieve Long Term Health, contains several initiatives affecting a broad range of Medicaid beneficiaries, including a program called Kentucky HEALTH, targeting adults who do not qualify for Medicaid on the basis of disability. Though Kentucky's waiver was slated to take effect in July 2018, a U.S. District Court vacated the Centers for Medicare & Medicaid Services' (CMS) approval of the waiver program. The waiver was remanded to the U.S. Department of Health and Human Services (HHS) for further review, and Kentucky is not moving forward with implementation at this time.¹

This brief describes the features of the Kentucky HEALTH waiver as approved by CMS on January 12, 2018. Kentucky HEALTH includes provisions similar to those implemented in other expansion waivers, such as enrollee contribution requirements and healthy behavior incentives, as well as some that have not previously been approved, such as disenrollment and lock out for failure to submit necessary information for eligibility redetermination. The waiver would also policies intended to transition enrollees from Medicaid to private coverage, including making work and community engagement a condition of eligibility. Kentucky was the first state to receive federal approval to implement such a requirement.

For more on the details of other approved Medicaid expansion waivers, see [Expanding Medicaid to the New Adult Group through Section 1115 Waivers](#).

Demonstration Goals

The state is seeking to accomplish several goals with the Kentucky HEALTH program, noting the following:

- Kentucky HEALTH will strengthen beneficiaries' engagement in their personal health care and provide incentives for responsible decision making.
- Requiring beneficiaries to pay monthly premium contributions will motivate them to use health services more efficiently.
- Incentives for beneficiaries to engage in healthy behaviors will result in better health outcomes, lower overall health care costs, and improved socioeconomic conditions.
- Community engagement requirements will help beneficiaries obtain employment, transition to commercial health insurance, and achieve improved health outcomes.²



Populations Covered

Kentucky HEALTH would cover expansion adults with incomes up to 138 percent of the federal poverty level (FPL), as well as non-disabled adults covered under traditional Medicaid, including parents, pregnant women, former foster care youth, and transitional medical assistance (TMA) beneficiaries.

Eligibility and Enrollment

Kentucky HEALTH would include several policies related to eligibility and enrollment, including those affecting the effective date of coverage, beneficiary reporting requirements for annual redeterminations and changes in circumstance, as well as a new work and community engagement requirement as a condition of eligibility.

Effective date of coverage

Kentucky HEALTH would include a waiver of the Medicaid requirement for three months of retroactive coverage, except for pregnant women and former foster care youth. Individuals who are medically frail would have coverage effective the first day of the month in which they applied for coverage.

Coverage for individuals subject to premiums (i.e., new adult enrollees, parents and caretakers, and TMA enrollees, but not people who are medically frail) would begin on the first day of the month in which the first premium payment is made. Individuals with incomes above 100 percent FPL who do not make an initial payment within 60 days would not be enrolled in Medicaid. Coverage for individuals with incomes below 100 percent FPL who do not make an initial payment would begin after the 60-day payment period expires.³ Individuals could also make an initial pre-payment to expedite coverage to the first day of the month in which the payment was made.

Beneficiary reporting requirements

Beneficiaries failing to provide information to complete the annual redetermination process would be disenrolled, and those who do not submit the required information within a 90-day reconsideration period would be locked out of coverage for up to six months. Additionally, beneficiaries who fail to report changes in circumstances affecting their eligibility within 10 days would be prevented from reenrolling for up to six months.⁴ These provisions would not apply to pregnant women, former foster care youth, and enrollees who are medically frail.⁵ Individuals who are disenrolled and locked out of coverage for failure to comply with these provisions could re-enroll prior to the end of the lock-out period with full benefits once every 12 month benefit period by paying a new initial premium contribution and attending a state-certified course on health or financial literacy. Kentucky would be required to provide beneficiaries with notice, education, and outreach about these policies; the state would also need to maintain the use of ex parte renewals (i.e., confirming continued Medicaid eligibility through third party data sources without requesting more information from the beneficiary), and prepopulated renewal forms.



Work and community engagement requirement

Kentucky HEALTH includes a work and community engagement requirement as a condition of Medicaid eligibility for adult waiver beneficiaries who are not exempt (Table 1). Non-exempt beneficiaries who either work at least 120 hours per month or meet certain conditions would be deemed to satisfy the work requirement automatically, while others would have to participate in qualifying activities for at least 80 hours per calendar month and document their participation on at least a monthly basis.⁶ Individuals who are newly subject to the work requirement (or have not been subject to it in the previous five years) would be given a three-month grace period before they have to meet it. Details regarding documentation and verification of beneficiary exemptions or compliance with the requirement are not included in the special terms and conditions of the waiver.

TABLE 1. Work and Community Engagement Requirement Exemptions and Qualifying Activities

Exempt	Non-exempt	
	Beneficiaries deemed to satisfy work requirement	Qualifying activities (80 hours must be completed and documented monthly)
<ul style="list-style-type: none"> former foster care youth pregnant women primary caregivers of a dependent minor child or disabled adult (limited to one caregiver per household) beneficiaries identified as medically frail beneficiaries diagnosed with an acute medical condition that would prevent them from complying with the requirements full-time students as determined by the state beneficiaries under age 19 or over 64 	<ul style="list-style-type: none"> employed at least 120 hours per calendar month meet the requirements of or are exempt from SNAP or TANF work requirements enrolled in the state's Medicaid-funded employer-sponsored insurance premium assistance program and their spouses or dependents 	<ul style="list-style-type: none"> job skills training job search activities education related to employment (e.g., management training) general education (e.g., high school, general equivalency diploma, college or graduate education, English as a second language) if not a full-time student vocational education and training self-employment (if less than 120 hours per month) subsidized or unsubsidized employment (if less than 120 hours per month) community work experience community or public service caregiving services for a non-dependent relative or other person with a disabling medical condition participation in substance use disorder treatment

Note: SNAP is the supplemental nutrition assistance program. TANF is temporary assistance for needy families. Individuals who are deemed to have satisfied satisfy the work requirement do not have to actively document their participation in qualifying activities, but the state would verify their compliance (details regarding how the state will verify compliance are not specified in the special terms and conditions of the waiver).

Source: CMS 2018.



Penalties for non-compliance. For beneficiaries who fail to meet the work and community engagement requirement for one month, Medicaid eligibility would be suspended unless they apply for and receive a good-cause exemption.⁷ In the month after failing to meet the requirement, beneficiaries could avoid suspension by completing all required hours for that month, and either make up missed hours or complete a state-approved health or financial literacy course. Otherwise, eligibility would be suspended effective the first day of the following month (i.e., two months after their initial failure to meet requirements). Eligibility would remain suspended until the first day of the month after the beneficiary completes 80 hours of qualifying activities in a 30-day period or a state-approved health or financial literacy course. If a beneficiary's eligibility is suspended on the date of his or her annual redetermination, eligibility would be terminated.⁸

State assurances. Prior to implementation of the waiver, Kentucky is required to make a number of assurances, including maintaining system capability to implement suspension of eligibility and lifting those suspensions (including suspending and reactivating capitation payments to managed care organizations), setting up systems to allow beneficiaries to report hours and seek data from other sources such as the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families, and ensuring timely and adequate beneficiary notices and outreach. Kentucky would also be required to provide appeal and due process mechanisms, make good faith efforts to connect beneficiaries to existing community supports (e.g., non-Medicaid transportation assistance, child care, and language services), assess areas within the state that have limited employment or educational opportunities to determine if further exemptions are warranted, and provide reasonable modifications for individuals with disabilities.⁹

Benefits

Waiver beneficiaries in the new adult group would continue to receive benefits through an alternative benefit plan, while pregnant women, former foster care youth, medically frail individuals, and other adults would continue to receive the Medicaid state plan benefit package. All beneficiaries under age 21 would continue to receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The state would not be required to provide non-emergency medical transportation (NEMT) to the new adult group for any services but would continue providing NEMT to other populations for most services, except for methadone treatment.¹⁰

Beneficiaries would be permitted to use money accrued in their My Rewards accounts to purchase additional services, including vision and dental services.

Beneficiary-Managed Accounts

Kentucky HEALTH beneficiaries would be provided with two member-managed health accounts—a deductible account, intended to cover the first \$1,000 of claims, and a My Rewards account, which could be used to purchase additional services.



Deductible account

The state would provide waiver beneficiaries—except for pregnant women and beneficiaries receiving employer-sponsored coverage through premium assistance—with a deductible account funded at \$1,000 at the beginning of the benefit year, which would cover claims associated with non-preventive services. This account is intended to educate beneficiaries about the cost of health services but exhausting the account within a benefit period would not affect beneficiaries' ability to access services. Up to 50 percent of any funds remaining at the end of the benefit period could be transferred to the rewards account.

My Rewards account

The state would provide all adult waiver beneficiaries with a My Rewards account that they could use to purchase additional benefits and approved items (e.g., vision and dental services, over-the-counter medications, limited fitness-related services).¹¹

Beneficiaries could add to their balances by completing healthy behavior activities and participating in community engagement activities that exceed the 80-hour participation requirement, and avoiding non-emergency use of the emergency department, as long as the account is active (i.e., an enrollee is not suspended) and they make their required premium payments. The state could reduce account balances for non-payment of premiums, non-emergency use of the emergency department, and missed appointments without good cause. The account balance could drop below zero but beneficiaries could not be charged.

Premiums

All waiver beneficiaries would be required to make monthly premium contributions, except for medically frail individuals, pregnant women, and former foster care youth.

Premium amounts. The waiver would allow the state to determine premium amounts but specifies that these amounts will be at least \$1 per month and no more than four percent of monthly income. If beneficiaries reach the 5 percent of income cap on out-of-pocket spending for a calendar quarter, their contributions would be reduced to the \$1 minimum premium for the remainder of the calendar quarter. The state must recalculate the required premium annually or whenever a member's circumstances change.¹²

Premium collection. Plans would be responsible for billing and collecting premiums. Monthly invoices must include information about how to report changes in income, how income is calculated, and the consequences for non-payment and failure to report changes in circumstance. Beneficiaries would be required to make their required premium payments within 60 days of the invoice to avoid non-payment penalties. Third parties would also be permitted to make premiums on behalf of beneficiaries.

Penalties for nonpayment. Members with incomes below 100 percent FPL, as well as medically frail individuals and former foster care youth, would be subject to copayments and have their rewards accounts suspended if they do not make premium payments for 60 days.¹³ Individuals with income above 100 percent FPL could be disenrolled and subject to a lockout period of up to six months.¹⁴ Members who re-



enroll following the full lockout period would not be required to pay past premium debt, although funds would be deducted from their My Rewards account.

All members could end their respective penalties early by meeting a good-cause exemption or completing the following steps:

- pay the premium required for the first month of coverage to restart benefits,
- make a one-time payment equal to premiums owed during their 60-day payment period, and
- attend an early re-enrollment educational course certified by the state on health or financial literacy.

Plans would not be permitted to report unpaid premiums to credit agencies, refer cases to debt collectors, or seek liens on members' homes or their earnings.

State assurances. Prior to implementation, the state would be required to make assurances, including providing beneficiaries with timely and adequate notice of policies related to premiums or actions that affect their eligibility; providing good cause exemptions from penalties; setting up processes to refund members for premium payments made for any months in which they were ineligible; and ensuring that reasonable modifications are made for individuals with disabilities protected by federal statute. In addition, the state would need to review the enrollees' eligibility for all other categories prior to disenrollment.¹⁵

Premium Assistance

The waiver would continue the state's existing employer-sponsored insurance (ESI) premium assistance program. Individuals enrolled in premium assistance would have their Medicaid eligibility re-determinations aligned with the ESI open enrollment period.

Delivery System

Kentucky would continue to use statewide mandatory managed care, except for individuals receiving coverage through the Medicaid-funded employer-sponsored insurance premium assistance program. Once individuals make their initial premium payment, beneficiaries would not be permitted to change plans without cause until their annual reenrollment period.

Endnotes

¹ *Stewart et al. v. Azar et al.*, 1:18-CV-00152 (U.S. District Court for the District of Columbia 2018).

² Demonstration goals also include those related to increasing access to substance use disorder (SUD) services, but they are beyond the scope of this fact sheet. Demonstration goals will inform the hypotheses in the state's evaluation design plan, if Kentucky HEALTH is enacted.

³ Individuals who are found eligible through presumptive eligibility would transition to being fully eligible on the first day of the month of the state's eligibility determination. Individuals known to be medically frail at the time of application would be



enrolled effective the first day of the month of application. Pregnant women and former foster care youth would be enrolled with effective dates consistent with Medicaid regulations (i.e., three months of retroactive eligibility).

⁴ The 10-day reporting window is not specified in the special terms and conditions, but is specified in the approval letter.

⁵ These provisions also would not apply if the individual needed and was not provided with reasonable modifications, or for individuals provided with a good cause exception for conditions such as hospitalization or other incapacitation of him or herself or an immediate family member, homelessness, being the victim of a natural disaster or domestic violence, and more.

⁶ The state would be required to provide reasonable accommodations for beneficiaries with disabilities protected by federal statute. These include, when necessary, exemptions from participation when an individual is unable to meet the requirement for disability-related reasons, modification in the number of hours required, and provision of support services.

⁷ Good cause exemptions must include, at minimum, certain circumstances that occur in the month in which the beneficiary failed to meet the requirements, including the beneficiary or an immediate family member has a disability or is hospitalized for a serious illness, the birth or death of a family member, severe inclement weather or a natural disaster, or a family emergency or life changing event (e.g., divorce or domestic violence).

⁸ Beneficiaries who newly qualify for an exemption (e.g., become pregnant, or enroll full-time in school) or become eligible through a Medicaid eligibility pathway not subject to the requirements during a suspension period could reactivate their eligibility.

⁹ While beneficiaries qualifying for Medicaid on the basis of disability would not be included in the waiver and as such would not be subject to the work and community engagement requirement, some individuals with disabilities qualify through a different eligibility pathway and may be subject to the requirement.

¹⁰ Individuals age 19 and 20 subject to early and periodic screening, diagnostic, and treatment services, pregnant women, and former foster care youth would continue to receive NEMT for all services including methadone treatment.

¹¹ Vision and dental services and over-the-counter medications would be covered at the rate in the Medicaid fee-for-service schedule and limited in scope to what beneficiaries would receive if they were not receiving the alternative benefit plan. When members seek benefits using the rewards account, Medicaid-enrolled providers should follow prior authorization processes to ensure the account contains a sufficient balance. The service would not be reimbursable if the account had insufficient funds. This would apply only to members receiving the alternative benefit plan; members receiving the state plan package receive these services through their managed care organization.

¹² Additionally, the state could vary amounts based on household size or length of enrollment, or other circumstances. It could reduce the required amount at any time but would only be permitted to increase it in response to evaluation results on an annual basis.

¹³ Copayment amounts would be equal to the copayments schedule in the Kentucky Medicaid state plan.

¹⁴ The state would be required to provide beneficiaries with 10 days advance notice of any adverse action.

¹⁵ The state would be required to offer good cause exemptions for certain conditions, including hospitalization or other incapacitation of the beneficiary or an immediate family member, homelessness, being the victim of a natural disaster or domestic violence.



References

Goldstein, A. 2018. Kentucky becomes the first state allowed to impose Medicaid work requirement. *Washington Post*, January 12. https://www.washingtonpost.com/national/health-science/kentucky-becomes-the-first-state-allowed-to-impose-medicaid-work-requirement/2018/01/12/b7b56e3e-f7b4-11e7-b34a-b85626af34ef_story.html?utm_term=.761428fd990d.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2018. Section 1115 of the Social Security Act Medicaid demonstration: Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH). January 12. Baltimore, MD: CMS. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf>.

